3 Tribal/Indian Health Clinic/ 638 Clinic Guidelines Contents

3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid services provided by Indian Health Clinics (IHC)/638 Clinics and other Medicaid services provided by Tribes but not covered under the Indian Health Clinic encounter, as deemed appropriate by Medicaid. It addresses the following:

- Claims payment
- Prior authorization
- Program policy
- IHC/638 Clinic services
- IHC/638 Clinics or Tribes as other Medicaid provider types
- Electronic claims billing
- Paper claims billing

3.1.2 Payment

Medicaid reimburses IHCs for most services through an all-inclusive rate for each participant encounter.

The all-inclusive rate for IHCs is established by the Federal Office of Management and Budget as published annually in the Federal Register.

Check eligibility to see if the participant is enrolled in Healthy Connections (HC), Idaho's Medicaid care management program. If a participant is enrolled, there are guidelines that must be followed to ensure reimbursement for providing Medicaid-covered services.

Tribal members enrolled with a primary care provider (PCP) other than the IHC do not need a referral for IHC services. However, a non-tribal member enrolled with a PCP other that the IHC will need a referral for IHC services.

3.1.3 Prior Authorization (PA)

IHC services do **not** require PA for IHC services for Native Americans and Alaskan Natives. However, if the IHC is enrolled with the Idaho Medicaid program as a provider for services other than IHC services, prior authorization **may** be required.

3.2 Policy – Indian Health Clinics

3.2.1 Overview

Medicaid covers **IHC/638 Clinic** physician services, physician assistant services, nurse practitioner services, nurse midwife services, clinical social worker services, clinical psychologist services and specialized nurse practitioner services, and any required supplies incidental to their services through an encounter reimbursement methodology. Medicaid covers dentist services provided in IHC.

For services other than IOHC/638 Clinic services or services provided by providers other than those listed above, follow the specific service definition and provider qualifications for the specific service listed in **Section 3.3**.

3.2.2 Excluded Services

3.2.2.1 Laboratory

If an outside lab instead of the clinic performs a laboratory service, the outside lab must bill Medicaid directly.

Laboratory services performed in IHCs are included in the encounter rate and cannot be billed as a separate service to Medicaid. The exception to this exclusion is when an individual receives laboratory service on a day when there is no encounter billed for a clinic visit. These laboratory services may be billed but the clinic must have a separate laboratory provider number or a group physician number to bill under **and** use laboratory procedure codes. The reimbursement will be fee-for-service rather than an encounter rate.

3.2.2.2 Pharmacy

Over-the-counter (OTC) pharmaceuticals are not covered by Medicaid, with the exception of those OTC items identified as payable in the *Idaho Medicaid Provider Handbook* for Pharmacies. Pharmaceutical services for take home prescription medications will be covered under the Medicaid Pharmacy Program. Claims must be submitted to Medicaid on the pharmacy claim form under the pharmacy's provider number. **The clinic may not bill pharmaceutical services as an encounter.**

3.2.3 Encounter Definition

An encounter is a face-to-face contact for the provision of medical, mental health or dental services between a clinic patient and a physician, physician assistant, nurse practitioner, clinical social worker, clinical psychologist, specialized nurse practitioner or visiting nurse, dentist or dental hygienist. A clinic may only bill a visiting nurse visit as an encounter if the patient is homebound and the clinic is providing home health services under the provision for home health in rural areas.

- Types of encounters include medical, mental health, and dental.
- Each contact with a separate discipline of health professional (medical, mental health, or dental) on the same day at the same location is considered a separate encounter and may billed as such.

- All contacts with all practitioners within a disciplinary category (medical, mental health, or dental) on the same day are considered one encounter.
- Reimbursement for services is limited to three (3) encounters (one of each type) per participant per day. An exception to this rule may be made if the encounter is caused by an illness or injury that occurs later the same day of the first encounter, requires additional diagnosis or treatment, and is supported by documentation.
- "No shows", visits to pick up medication, or incidental services on the day of the encounter are not considered an encounter.

3.2.4 Incidental Services

Services incidental to a billable encounter are:

- In-house radiology
- Physical therapy
- Occupational therapy
- Speech therapy
- Audiology
- In-house laboratory services
- In-house nutritional education or dietary counseling and monitoring by a registered dietitian
- Injectable medications
- Medical equipment and supplies

These services are not separately billable as an encounter. If they happen on the same day as an encounter visit they are considered included in the encounter rate.

If these services are provided by the clinic on a day when a qualifying IHC or Federally Qualified Health Center encounter is not provided, the clinic must have the appropriate separate provider number to bill for those services (see **Section 3.3**).

IHCs may bill for one medical, one mental health, and one dental encounter in one day.

3.2.5 Dental Encounter

An encounter is a face-to-face contact for the provision of dental services between a participant and a dentist or dental hygienist. When billing for dental services, use the dental encounter code **D2999** with the diagnosis code **V72.2.** Dental services are limited for Medicaid participants. For additional information about services considered a benefit of the dental program, see the Dental Guidelines in Section 3 of the *Idaho Medicaid Provider Handbook*.

http://www2.state.id.us/dhw/medicaid/provhb/s3_dental.pdf

3.2.6 Medical Care Evaluation for Assessment

The Medicaid Care Management Program for adults with developmental disabilities includes an assessment process which requires a history, physical examination, and referral from the physician (the participant's HC provider, if applicable).

Medicaid will reimburse history and physicals for adults when it is a Medicaid program requirement such as above. When billing for history and physical exams for developmentally disabled adults that have been requested by the Medicaid program, use diagnosis code **V70.3** (other medical examination for administrative purposes). You must enter *"State required history and physical"* in the comments field of the claim or it will deny.

3.2.7 Advance Directives

An advance directive explains to a participant his or her right to accept or refuse medical services, or to choose among available medical services. The provider will inform the participant of his/her right to formulate advance directives, such as a "Living Will" and/or "Durable Power of Attorney for Health Care." Medicaid has directed that providers of home health care (including FQHCs and IHCs) must provide all adult Medicaid participants with advance directive information in an understandable format.

If a participant is unable to read the information, the information is read to the participant by a relative or friend. If no one else is available, the provider must read the advance directive information to the participant. If the provider is unable to abide by the medical desires of the participant, the provider is required to assist the participant in finding an alternative source of service.

3.2.8 Procedure Codes

Idaho Medicaid uses the federally mandated HCPCS. Except for dental services, all claims must use the procedure code **T1015**, the encounter code for all medical and mental health IHC services. Bill dental services with procedure code **D2999**.

- Children's EPSDT services: see Section 3.2.8 for more information.
- Family planning services: see **Section 3.2.9** for more information.

The federal Department of Health and Human Services announces new rates for Tribes for outpatient encounter (per visit) rates every year. These rates are effective January 1 of each year. IHCs should bill with the most current encounter rate. This practice will allow the Department to run mass adjustments in the event that the claims processing system does not have the most current rate of file as of January 1. However, claims that were billed with a modifier must be manually adjusted. An example of these claims would be EPSDT visits. See the **Section 2**, **General Billing**, for instructions on submitting a manual adjustment for these claims.

3.2.9 Medicare Crossover

Participants may be dually eligible for Medicare and Medicaid. The provider must first bill Medicare for rendered services. A copy of the Medicare Remittance Notice (MRN) must be attached to the Medicaid claim when billing on paper. If billing electronically, the information from Medicare must be entered in appropriate screens.

See **General Billing Information, 2.5**, Crossover Claims, for further information.

3.2.10 Place of Service Codes

The following place of service codes are valid for IHCs. Enter the appropriate code in the place of service field on the CMS-1500 claim form or in the appropriate field when billing electronically:

05	Indian Health Service Free-standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
11	Office
50	FQHC
72	EPSDT Services

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is designed to provide periodic medical exams of Medicaid-eligible children for early detection of medical and developmental problems.

All EPSDT services are based on guidelines established by the Centers for Medicare and Medicaid Services (CMS).

3.2.10.1 Medical Screen Eligibility

All Medicaid eligible children ages birth through the last day of the month of their twenty-first (21) birthday are eligible for EPSDT exams. Parents periodically receive an informational letter reminding them the child is due to have an EPSDT screen (well baby or well child exam).

Medicaid follows the American Academy of Pediatrics Periodicity Schedule. The screen must include the appropriate laboratory tests for that periodicity schedule. The schedule is provided in ***Section 1.6, General Provider and Participant Information, EPSDT***.

3.2.10.2 Diagnosis Codes

Use diagnosis code **V20.1** — Other Healthy Infant/Child, or **V20.2** — Routine Infant or Child Preventive Medicine Exam for all EPSDT exam claims.

It is important that you enter these diagnosis codes for routine exams for children. There are federal reporting requirements that the State must send to CMS regarding numbers of children who receive the appropriate well-child services.

3.2.10.3 Blood Lead Screening

Federal mandate requires a screening for lead poisoning as a required component of an EPSDT screen. Current CMS policy requires a screening blood lead test for all Medicaid-eligible children at 12 and 24 months of age. In addition, children over the age of 24 months, up to 72 months of age, should receive a screening blood lead test if there is no record of a previous test.

See **Section 1.5.5.4** for the complete EPSDT Screening and Immunization Schedule.

3.2.10.4 Payment for EPSDT Screening

Payment for EPSDT screens is the same as the rate for each all inclusive participant encounter. Providers report encounter code ***T1015*** with a modifier signifying that the service is part of an EPSDT screening.

3.2.10.5 EPSDT Modifiers

Modifier	Modifier Description
U6	Participant is referred to another provider.
EP	Service provided as part of Medicaid EPSDT program
25	(Description change only): Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.

3.2.11 Family Planning

All claims for services or supplies that are provided as part of a family planning visit must include the **FP** (Family Planning) modifier with encounter code **T1015**. Additionally, any family planning encounters should include one of the diagnoses listed in the table below as the **primary** diagnosis.

Diagnosis Code	Description
V25.01	Prescription of oral contraceptive
V25.02	Initiation of other contraceptive measure (fitting of diaphragm, prescription of foams, creams, other agents)
V25.09	Family planning advice (other)
V25.1	Insertion of intrauterine contraceptive device
V25.2	Sterilization (admission)
V25.40	Contraceptive surveillance, unspecified
V25.41	Contraceptive pill surveillance
V25.42	Intrauterine device (checking, reinsertion, or removal of device) surveillance
V25.43	Implantable subdermal contraceptive surveillance
V25.49	Surveillance of other contraceptive method
V25.5	Insertion of implantable subdermal contraceptive
V25.8	Other specified contraceptive management (post-vasectomy sperm count)
V25.9	Unspecified contraceptive management

3.3 IHC/638 Clinics as Other Medicaid Provider Types

3.3.1 Overview

IHCs provide many services that may not be billable as an IHC encounter. An IHC or Tribe may apply for and receive provider numbers to bill for these additional services. The service descriptions, provider qualifications, prior authorization requirements (if applicable), limitations (if applicable), and where to apply for provider status are listed in this section.

3.3.2 Mental Health Clinic Services

3.3.2.1 Description

Mental Health Clinic services are designed to foster better mental health for Medicaid participants. In accordance with the Code of Federal Regulations 42 CFR 440.90, all mental health clinic services must be provided at the clinic, unless provided to an eligible homeless individual. A mental health clinic must be under the supervision of a physician. Clinic services are typically preventative, diagnostic, therapeutic, rehabilitative, or palliative services. Recreational, educational, and vocational services are not Medicaid covered Mental Health Clinic services. IHCs that obtain Mental Health Clinic provider status are governed by rules governing services provided in a Mental Health Clinic. These rules are located at IDAPA 16.03.09.464 – 472. Billable services include:

- Psychotherapy (evaluation; individual, group and family therapy).
- Partial Care – structured therapeutic interventions that assist participants in the stabilization of behavior, functional skill acquisition.
- Collateral Contact – contact may be billed as collateral contact when it is necessary to provide consultation or treatment direction about a Medicaid participant to a “significant other” in the participant’s life, or another individual with a primary treatment relationship to the participant. The need for collateral contact should be clearly reflected in the participant’s treatment plan. It must be:
- Authorized on the treatment plan
- Provided by agency staff qualified to deliver clinical services
- Documented in the progress notes
- The contact must be face to face
- Nursing Services
- Pharmacologic Management
- Occupational Therapy Evaluations and therapy

3.3.2.2 Limitations

Twelve hours of evaluative or diagnostic services and individualized treatment plan development are payable per calendar year per participant. This limitation includes all fee-for-service evaluation/diagnostic services paid to all providers and provider types.

Psychotherapy services, including group or family psychotherapy are limited to no more than forty-five (45) hours per calendar year per participant.

Partial care services are payable up to a maximum of fifty-six (56) hours per week per eligible participant. Effective 05/01/2005, the maximum is thrity-six (36) hours per week per eligible participant.

3.3.2.3 Provider Qualifications

Licensed, qualified professionals providing mental health clinic services to eligible Medicaid participants must have, at a minimum, one (1) or more of the following qualifications:

- Licensed Psychiatrist; or
- Licensed Physician; or
- Licensed Psychologist; or
- Psychologist Extender, registered with the Board of Occupational Licenses; or
- Licensed Masters Social Worker, Licensed Clinical Social Worker, or Licensed Social Worker; or
- Licensed Clinical Professional Counselor or Licensed Professional Counselor; or
- Licensed Marriage and Family Therapist; or
- Certified Psychiatric Nurse, R.N., as described in IDAPA 16.03.09.456.02; or
- Licensed Register Nurse, R.N.; or
- Registered Occupational Therapist, O.T.R.

Apply to become a Mental Health Clinic through EDS Provider Services.

3.3.2.4 Procedure Codes

IHCs that choose to enroll as a Mental Health Clinic must follow the guidelines published in the *Idaho Medicaid Provider Handbook,* Section 3 Clinic Guidelines.

http://www2.state.id.us/dhw/medicaid/provhb/s3_clinic.pdf

3.3.3 Rehabilitative Services

3.3.3.1 Description

IHCs that wish to provide community-based mental health services must do so under a Psychosocial Rehabilitation Provider agreement. Psychosocial rehabilitative services are not limited to a clinic setting as are Indian Health Clinic and Mental Health Clinic services. The rules governing the provision of these services are located at IDAPA 16.03.09.449-459. Also see Section 3 of the rehab options.

http://www2.state.id.us/dhw/medicaid/provhb/s3_rehab option.pdf

Rehabilitative Mental Health Services (also called Rehab Option or PSR services) include treatment, rehabilitation, and supportive services. The goal of rehabilitative services is to reduce to a minimum an individual's mental disability and restore the participant to the highest functional level within the community. Billable services include:

- Comprehensive assessment (See IDAPA 16.03.09.453.01)
- Written service plan (See IDAPA 16.03.09.453.02
- Pharmacological management (See IDAPA 16.03.09.453.03)
- Individual psychosocial rehabilitation (See IDAPA 16.03.09.453.04)
- Group psychosocial rehabilitation (See IDAPA 16.03.09.453.05)
- Crisis intervention service (See IDAPA 16.03.09.453.06)
- Collateral contact (See IDAPA 16.03.09.453.07)
- Nursing services (See IDAPA 16.03.09.453.08)
- Psychotherapy (See IDAPA 16.03.09.453.09)
- Occupational therapy (See IDAPA 16.03.09.453.10)

http://www2.state.id.us/adm/adminrules/rules/idapa16/0309.pdf

3.3.3.2 Provider Qualifications

Licensed, qualified professionals providing Psychosocial Rehabilitation services to eligible Medicaid participants must have, at a minimum, one (1) or more of the following qualifications:

- Licensed Physician or Psychiatrist; or
- Licensed Master's Level Psychiatric Nurse; or
- Licensed Psychologist; or
- Licensed Clinical Professional Counselor or Licensed Professional Counselor; or
- Licensed Marriage and Family Therapist; or
- Licensed Masters Social Worker, Licensed Clinical Social Worker; or
- Clinician; or
- Licensed Pastoral Counselor; or
- Licensed Social Worker; or
- Licensed Professional Nurse (R.N.); or
- Psychosocial Rehabilitation (PSR) Specialist; or
- Registered Occupational Therapist, O.T.R.; or
- Psychologist Extender

Apply to become a Psychosocial Rehabilitation Provider through the Regional Mental Health Program.

http://www2.state.id.us/adm/adminrules/rules/idapa16/0309.pdf

3.3.3.3 Eligibility

Children with a serious emotional disturbance (SED) are eligible for rehabilitative mental health services. See IDAPA 16.03.09.450 for qualifying criteria. Also, persons who are 18 years of age or older with a diagnosis of severe and persistent mental illness that directly impacts at least two identified functional areas are eligible for theses services. Rules governing the provision of these services are located at IDAPA 16.03.09.449-459.

3.3.3.4 Limitations

- Assessment and Service Plan Development – limited to 6 hours annually.

- Psychotherapy – limited to 24 hours annually.
- Crisis Intervention Service – limited to 20 hours per crisis during any consecutive 5-day period. Must be prior-authorized or authorized retrospectively.
- Psychosocial Rehabilitation – limited to 20 hours per week.

3.3.3.5 Procedure Codes

IHCs that choose to enroll as a Psychosocial Rehabilitation provider should refer to the *Idaho Medicaid Provider Handbook,* Section 3 Rehabilitative and Health Related Services Guidelines, for procedure codes and specific billing instructions. This section can be accessed online at:

http://www.healthandwelfare.idaho.gov/DesktopModules/DocumentsSortable/DocumentsSrtView.aspx?tabID=0&ItemID=582&MId=10826&wversion=Staging

3.3.3.6 *Prior* Authorization (PA)

Psychosocial Rehabilitation services require PA from the Mental Health Authority.

3.3.4 Case Management Services (Service Coordination)

3.3.4.1 Description

IHCs who want to bill for service coordination services must do so under a Service Coordination provider agreement. (See rules at IDAPA 16.03.17.) Service Coordination is defined as a brokerage model of case management.

Reimbursable services include:

- Assessment and service plan development
- Linking the individual to services
- Monitoring and coordinating services

3.3.4.2 Provider Qualifications

All service coordinators must have a minimum of the following:

- BA or BS degree in a human services field from a nationally accredited university or college; or
- Licensed professional nurse (R.N.); and
- A minimum of one (1) year experience working with the population they will be serving or be supervised by a qualified service coordinator; and
- Pass the Department's criminal history check.
- Agencies may use paraprofessionals to assist in the implementation of a Service Coordination plan (except for plans for participants with mental illness). Paraprofessionals must:
- Be able to read and write at a level equal with the paperwork and forms involved in the provision of the service; and
- Pass the Department's criminal history check.

Apply to become a Service Coordination Provider:

- for PCS/HCBS and DD populations, contact your Regional Medicaid Services
- for EPSDT Service Coordination, contact your Regional Children's ACCESS Unit
- for Mental Health Service Coordination, contact EDS Provider Enrollment

http://www2.state.id.us/adm/adminrules/rules/idapa16/0317.pdf

3.3.4.3 Eligibility

Medicaid reimburses for Service Coordination services for four target populations:

- Individuals eighteen years of age or older diagnosed with a developmental disability who have substantial functional limitations in three or more major life areas and need assistance to adequately access services and supports necessary to maintain their independence in the community; (IDAPA 16.03.17.201)
- Individuals (adults and children) who have been approved to receive state plan personal care services or home and community based waiver services and require assistance to access services and supports to maintain their independence in the community; (IDAPA 16.03.17.202)
- Individuals eighteen years of age or older who are using or have a history of using high cost medical services associated with periods of increased severity of mental illness; and are diagnosed with a condition of severe and persistent mental illness that is listed in the DSM-IV-TR) (See IDAPA 16.03.17.203.02 for classification codes); and have illness of sufficient severity to cause a disturbance in their role performance or coping skills in at least two life areas on a continuous or intermittent basis. (IDAPA 16.03.17.203)
- Children from birth through the month of their twenty-first (21st) birthday identified in an EPSDT screen as having a **developmental delay or disability, special health care needs, or severe emotional disorder** and need assistance in one or more of the problems listed at IDAPA 16.03.17.204.03 associated with their diagnosis. (IDAPA 16.03.17.204)

3.3.4.4 Limitations

Service Coordination services are not reimbursable for participants who receive hospice services or live in a hospital, nursing facility, or ICF/MR. Service Coordination services are also limited to:

- 5 hours per month for participants with mental illness.
- 8 hours per month for participants receiving personal care or waiver services.
- Flat monthly fee for individuals with developmental disabilities and children.
- 6 hours for the initial assessment and plan development (one time reimbursement).
- See IDAPA 16.03.17 for additional reimbursement for crisis Service Coordination.
- Participants are only eligible for one type of service coordination at a time.

- Service coordination is not reimbursable when the individual is incarcerated.

3.3.4.5 Procedure Codes

IHCs that choose to enroll as a Service Coordination provider should refer to the *Idaho Medicaid Provider Handbook,* Section 3 Service Coordination Guidelines, for procedure codes and specific billing instructions.

3.3.4.6 Prior Authorization

All Service Coordination services (except for Service Coordination services for individuals with severe and persistent mental illness) must be prior authorized by the Department.

3.3.5 Personal Care Services

3.3.5.1 Description

The number of American Indian and Alaska Native (AIAN) elders is growing rapidly. This places new pressures on Indian Health Services (IHS) to provide long-term care for AIAN elders. Institutional care is not desired by most elders and has high costs for both the elders and the tribal governments. In contrast, less expensive home care can provide enough assistance to keep most disabled elders in their own or their relatives' homes, where they prefer to be. Medicaid covers in-home services both through state plan personal care services or, for participants with more complex needs, through the Aged/Disabled Home and Community Based Services waiver.

IHS should apply to be a provider of these services for the following reasons:

- To help AIAN elders and disabled participants who need assistance with daily activities like bathing, dressing, etc.
- To create new sources of employment for tribal members while offering culturally competent care
- To generate new revenue for tribal health programs

Personal care services are medically oriented tasks related to a participant's physical care in the home. (See IDAPA 16.03.09.146 for rules governing this service.) Such services must be included in an approved plan of care and include, but are not limited to, the following:

- Assistance with personal hygiene
- Assistance with medications that are ordinarily self-administered
- Meal preparation
- Incidental household services essential to the participant's comfort, safety and health
- Independence training

3.3.5.2 Provider Qualifications

All personal assistants must have at least one (1) of the following qualifications:

- Licensed Registered Nurse (R.N.)
- Licensed Practical Nurse (L.P.N.)

- A person who meets the standards of section 39-5603 of Idaho Code and receives training to ensure the quality of services. Must be at least 18 years of age. The RMS may require a Certified Nursing Assistant (CNA) if, in their professional judgment, the participant's medical condition warrants a CNA.

To apply to be a Personal Care Services Provider, contact your Regional Medicaid Services (RMS).

3.3.5.3 Eligibility

Adults and children are eligible for this service if the service is determined to be medically necessary, ordered by a physician and provided in accordance with a written plan of care.

3.3.5.4 Limitations

Personal care services under the State Plan Option are limited to:

- 16 hours per week per participant
- Participants who meet medical necessity criteria under EPSDT (IDAPA 16.03.09.535 may receive up to twenty-four (24) hours per day of service delivery through the month of their twenty-first (21st) birthday
- Must be provided in the participant's home or personal residence

3.3.5.5 Procedure Codes

IHCs that choose to enroll as a Personal Care Services (PCS) provider should refer to the *Idaho Medicaid Provider Handbook*, Section 3 Personal Care Services Guidelines, for procedure codes and specific billing instructions.

3.3.5.6 Prior Authorization (PA)

The RMS must authorize all services reimbursed by Medicaid under the PCS program prior to the payment of services. Approved authorizations are valid for the dates shown on the PA. The PA number must be indicated on the claim.

3.3.6 Aged and Disabled Waiver Services

3.3.6.1 Description

Idaho's elderly and disabled citizens can often maintain self-sufficiency, individuality, independence, dignity, choice and privacy in a cost-effective home-like setting instead of an institution. These services may be provided in the person's own home or apartment; the home of relatives who are primary non-paid care providers; adult foster homes; residential care facilities; assisted living facilities; and the community. They include:

- Adult Day Care
- Adult Residential Care
- Non-medical transportation
- Specialized medical equipment and supplies
- Attendant Care

- Psychiatric Consultation
- Case Management
- Chore services
- Companion services
- Consultation services
- Homemaker services
- Home-Delivered meals
- Environmental accessibility adaptations
- Respite care services
- Nursing services
- Personal Emergency Response services

3.3.6.2 Provider Qualifications

All providers of homemaker, respite care, adult day care, transportation, chore, companion, attendant adult residential care, home delivered meals, and behavior consultation must meet, either by formal training or demonstrated capacity, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks/activities in the Department's approved Aged and Disabled waiver as approved by the Centers for Medicare/Medicaid Services (CMS).

A waiver provider cannot be the spouse or parent of a minor child to whom they are providing services.

To apply to be an Aged and Disabled Waiver provider, contact your Regional Medicaid Services (RMS).

- Adult Day Care - Must meet all applicable state laws and regulations and have adequate staff to meet the needs of the participants accepted for admission.
- Adult Residential Care – Must meet all applicable state laws and regulations and have adequate staff to meet the needs of the participants accepted for admission.
- Non-medical transportation – Must be enrolled as a waiver provider and have a valid driver's license and liability insurance for the vehicle operated.
- Specialized medical equipment and supplies – Must be enrolled in the Medicaid program as a participating medical vendor provider.
- Attendant Care – must be an employee of an agency or fiscal intermediary and selected, trained and supervised by the participant or the participant's family.
- Psychiatric Consultation – Master's degree in a behavioral science; and be licensed in accordance with state law/regulations; or have a BA and work for an agency with direct supervision from a licensed Ph.D. psychologist and have one (1) year experience in treating severe behavior problems.
- Case Management – Must meet the same requirements as a PCS Service Coordinator (See IDAPA 16.03.17)

- Chore services – Must be employed by an agency or fiscal intermediary. If employed by a fiscal intermediary, the employee is selected, trained and supervised by the participant or participant's family. The provider must be skilled in the type of service to be provided and demonstrate the ability to provide services according to a Plan of Care.

- Companion services – Must be employed by an agency or fiscal intermediary. If employed by a fiscal intermediary, the employee is selected, trained, and supervised by the participant or participant's family.

- Consultation services – Must be provided through a PCS agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training and supervising their own providers.

- Homemaker services - Must be employed by an agency or fiscal intermediary. If employed by a fiscal intermediary, the employee is selected, trained and supervised by the participant or participant's family. Must be capable of providing the duties on the Service Plan.

- Home-Delivered meals – Must be a public agency or private business capable of 1) supervising the direct service; 2) providing assurances that each meal meets one-third (1/3) of the Recommended Daily Allowance as defined by the Food and Nutrition Board of National Research Council; 3) delivering meals in accordance with the plan of care in a sanitary manner at the correct temperature for the specific type of food; 4)maintain documentation that the meals served are made from the highest USDA grade for each specific food type; and 5) must be inspected and licensed as a food establishment by the District Health Department.

- Environmental accessibility adaptations – Must be provided by an individual or business properly licensed or certified to provide the necessary home modifications.

- Respite care services – Meet the qualifications for the type of services to be rendered, have received instructions in the needs of the participant who will be provided the service; demonstrate the ability to provide services according to a Plan of Care; have good communication and interpersonal skills; be willing to accept supervision by a provider agency or the primary caregiver; and be free of communicable diseases.

- Nursing services – Must be licensed as an R.N. or L.P.N. in Idaho or practicing on a federal reservation and licensed in another state.

- Personal Emergency Response services – Must have a Land Mobile License from the FCC.

3.3.6.3 Eligibility

To be eligible for Medicaid payment of waiver services, the RMS must determine that the all of the following criteria are met:

- The participant requires services due to a physical or cognitive disability, which results in a significant impairment in functional independence as demonstrated by findings of a Uniform Assessment Instrument (UAI); and

- The participant is capable of being maintained safely and effectively in a non-institutional setting; and
- The participant would need to reside in a nursing facility in the absence of waiver services. Medicaid expenditures for the care of the participant in the community will be no more than the Medicaid program costs would be for that participant's care in a nursing facility.

3.3.6.4 Procedure Codes

IHCs that choose to enroll as an Aged & Disabled Waiver provider should refer to the *Idaho Medicaid Provider Handbook,* Section 3 Aged and Disabled Guidelines, for procedure codes and specific billing instructions.

3.3.6.5 Prior Authorization (PA)

The RMS unit in the Region must authorize all services reimbursed by Medicaid under the A&D waiver program before services are rendered. The PA number must be included on the claim.

3.3.7 Physician/Osteopath Provider Group

3.3.7.1 Description

There are times when a tribe cannot bill for services under the encounter. By having a Physician Group provider number, the tribe would have an avenue to bill for these services. Examples are:

- Pathology/Laboratory services provided when there has not been a qualifying office visit on the same day
- Visits by the physician when a patient is in a hospital or nursing facility
- Radiology services provided when there has not been a qualifying office visit on the same day
- Diabetes Education and Training

3.3.7.2 Provider Qualifications

All physicians/osteopaths, licensed to practice medicine in any U.S. state, are eligible to participate in the Idaho Medicaid program. They must obtain an Idaho Medicaid provider number from the Idaho Medicaid program.

To apply to be a physician, osteopath, or mid-level provider, contact EDS Provider Enrollment at (800) 685-3757.

Services provided by employees of a physician/osteopath may not be billed directly to the Idaho Medicaid program. There are two exceptions:

- psychological testing services provided by a licensed psychologist or social worker
- diabetes education and training (counseling) provided by a Certified Diabetes Educator

Psychological testing services

Physician/osteopath groups may bill for psychological testing services provided by a licensed psychologist or social worker. They are billed under the physician/osteopath's provider number. **This exception applies to testing only.**

Diabetes Counseling Education

Physician/osteopath groups may bill for diabetes education and training (counseling) provided by a Certified Diabetes Educator (CDE) through an American Diabetes Association (ADA) Recognized Diabetes Education Program.

Diabetes education and training services are limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years.

A one-time provider review is required in order to provide Diabetes Counseling/Education Training. The following information must be sent to Cindy Taylor at P.O. Box 83720, Boise, ID 83720-0036 or faxed to (208)364-1911:

- Current Idaho Medicaid provider number (for Tribes, this must be a physician clinic number, not their IHC number)
- Whether you will be providing individual or group counseling/education
- A current copy of the diabetic counselor's certificate

Mid-level practitioners

IHCs who provide clinic services though a nurse practitioner, physician assistant, or a nurse midwife must obtain a mid-level provider number for non-encounter services provided by these practitioners.

3.3.7.3 Procedure Codes

IHCs that choose to enroll as a Physician/Osteopath provider should refer to the *Idaho Medicaid Provider Handbook,* Section 3 Physician/Osteopath Guidelines, for procedure codes and specific billing instructions.

3.3.8 Audiology Services

3.3.8.1 Overview

If Audiology services are provided on the same day as an encounter, the service is considered part of the encounter. If rendered by a provider other than listed as those who can provider IHC services, an Audiology provider number must be obtained.

3.3.9 Vision Services

Services provided by an ophthalmologist are billable as an encounter under the IHC/638 Clinic number. However, vision exams provided by other qualified providers such as optometrist must be billed under a Vision service provider agreement.

3.3.10 Physical Therapy

3.3.10.1 Overview

Medicaid covers physician-ordered physical therapy rendered by a licensed physical therapist in the participant's home or in the therapist's office.

- Must be part of a plan of care.
- Progress must be reviewed and plan updated every 30 days unless the therapist has documentation from the physician indicating that a chronic condition exists that will require therapy for more than six (6) months. In these cases, a physician order for continued care is required every six (6) months.
- The plan of care must stipulate the type of physical therapy needed, the frequency of treatment, expected duration, anticipated outcomes, M.D. signature and date. A copy of the order must be maintained in the participant's file.

To apply to be a Physical Therapy provider, contact EDS Provider Enrollment.

3.3.10.2 Limitations

Physical therapy visits are limited to twenty-five (25) visits per participant during any calendar year (January through December) regardless of the billing provider. Visits exceeding the 25-visit limitation must be prior authorized before services are rendered. See the *Idaho Medicaid Provider Handbook,* Section 3 Health Care Providers of the Healing Arts, for specific prior-authorization information.

3.3.10.3 Documentation

The plan of care is not required as an attachment to the claim, but must be maintained by the provider.

3.3.10.4 Excluded Services

The following services are excluded from payment as physical therapy:

- Group exercise therapy
- Group hydrotherapy
- Acupuncture
- Biofeedback

3.3.11 Pathology/Laboratory

Pathology/laboratory services provided on a day when the patient does not see a health care provider in the clinic may **not** be billed as an encounter. The provider may bill for the laboratory services in these instances under a physician group provider number as previously mentioned or may apply for a laboratory provider number through EDS.

To apply to be a pathology/laboratory provider, contact EDS Provider Enrollment.

3.3.12 Radiology

Radiology services provided on a day when the patient does not see a health care provider in the clinic may **not** be billed as an encounter. The provider may bill for the radiology services by applying for a radiology provider number through EDS.

To apply to be a radiology service provider, contact EDS Provider Enrollment.

3.3.12.1 Covered Services

The technical component includes charges for the following:

- Personnel
- Material, including usual contrast media and drugs
- Film or xerograph
- Space, equipment, and other facility charges

The technical component does not include radioisotopes or non-iodine contrast media. List the separate charges for radioisotopes. To be assured of adequate reimbursement, attach an invoice identifying the cost of the radioisotope, the manufacturer, and the strength and dosage administered, or attach medical records with the related information. Because of the wide variations in costs, to providers and the radioisotopes billed, this information is necessary to price each claim.

3.3.12.2 Modifiers

To identify a charge for the technical component, use the appropriate five digit CPT procedure code with the TC modifier.

For more details on billing codes, see the *Idaho Medicaid Provider Handbook*, Section 3 Healing Arts Guidelines.

3.3.13 Home Health

IHCs are allowed to bill for Home Health visits for patients that are homebound. However, the homebound is not a requirement for Home Health. Clinics who wish to provide home heath services for non-homebound Medicaid participants must apply for a Home Health Provider agreement through EDS. See the *Idaho Medicaid Provider Handbook*, Section 3 Home Health Guidelines, for details.

3.3.14 Hospice

Hospice services may only be provided through a hospice provider agreement. See the *Idaho Medicaid Provider Handbook*, Section 3 Hospice Guidelines, for details.

3.3.15 Dietitian Services

Medicaid allows reimbursement for Dietitian services in very limited circumstances. See the *Idaho Medicaid Provider Handbook*, Section 3 Health Care Providers of the Healing Arts Guidelines, for more information.

3.3.15.1 PWC Nutritional Services

Nutritional services for women on the PWC program may be billed when all of the following criteria are met:

- Must be ordered by a physician, nurse practitioner, or nurse midwife
- Must be delivered after confirmation of pregnancy
- Extends only through the 60th day after delivery
- Limited to two (2) visits during the covered period

3.3.15.2 EPSDT Nutritional Services

Nutritional services for children through the month of their twenty-first (21) birthday when all of the following criteria are met:

- Must be identified through an EPSDT screen
- Must be ordered by a physician
- Must be determined to be medically necessary
- Cannot be due to obesity
- Must be billed with diagnosis code V20.1 or V20.2
- Limited to two (2) visits per calendar year without PA; up to two (2) additional visits may be allowed with PA by the EPSDT Coordinator.

3.3.16 Podiatry

Medicaid covers podiatry services rendered for acute foot conditions. Acute foot conditions are defined as any condition that hinders normal function, threatens the individual, or complicates any disease. However, preventative foot care may be provided in the presence of vascular restrictions or other systemic diseases.

3.3.16.1 Service limitations

The following podiatry services are covered only under specific conditions:

- Care of the foot and ankle – limited to the area from the mid-calf down
- Orthotics – only if prior-authorized
- Muscle testing and range of motion studies – only if billed separately from outpatient visits for evaluation and management. Medicaid considers these services part of a routine office visit.
- Surgical removal of corns and calluses – only when there is systemic disease present
- Cutting, removal, debridement or other surgical treatment of toenails – only when there is an acute condition or systemic disease present

3.3.16.2 Non-covered Services

The following podiatry services are generally not covered:

- Daily care in an inpatient hospital setting (reviewed on a case by case basis)
- Daily inpatient care in a long term care facility (NF or ICF/MR)

3.3.16.3 Diagnosis Codes

All claims must list the appropriate ICD-9-CM diagnosis code for acute conditions. The acute condition must be indicated on the initial claim and all subsequent claims.

3.4 Claim Billing

3.4.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within one year of the date of service.

3.4.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

In addition to new HIPAA-required fields, the changes listed in ***Guidelines for Electronic Claims*** are effective October 20, 2003.

3.4.2.1 Guidelines for Electronic Claims

See **Section 2** for more information on electronic billing.

Detail lines
Idaho Medicaid allows up to **50** detail lines for electronic HIPAA 837 Professional claims.

Referral number
A referral number is required on an electronic HIPAA 837 Professional claim when a participant is referred by another provider. Use the referring provider's Medicaid provider number, unless the participant is a Healthy Connections participant. For Healthy Connections participants, enter the provider's Healthy Connections referral number.

Reporting of the Healthy Connections referral number is not required for the participant's Healthy Connections Primary Care Physician.

Prior authorization (PA) numbers
Idaho Medicaid allows more than one PA number per electronic HIPAA 837 Professional claim. PAs can be entered at the header or detail of the claim.

Modifiers
Up to **4** modifiers per detail are allowed on an electronic HIPAA 837 Professional claim.

Diagnosis codes
Idaho Medicaid allows up to **8** diagnosis codes on an electronic HIPAA 837 Professional claim.

Electronic crossovers
Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.4.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2004 is entered as 07/04/2004

3.4.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed unless EDS has a signature on file.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

3.4.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.4.3.3 Completing Specific Fields

Consult the Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the seven-digit participant ID number exactly as it appears on the plastic participant ID card.
2	Patient's Name	Required	Enter the participant's name exactly as it appears on the Medicaid plastic ID card. Be sure to enter the last name first, followed by the first name and middle initial.
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required if applicable	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable	Required if field 11d is marked YES.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate yes or no if this condition is related to the participant's employment.
10b	Auto Accident?	Required	Indicate yes or no if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate yes or no if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check yes or no if there is another health benefit plan. If yes, return to and complete items 9a-9d.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections participant. Enter the referring physician's name.
17a	ID Number of Referring Physician	Required if applicable	Use this field when billing for a consultation or Healthy Connection participant. Enter the referring physician's Medicaid provider number. For Healthy Connections participants, enter the provider's Healthy Connections referral number.

Field	Field Name	Use	Directions
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to 4) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required if applicable	If applicable, enter the prior authorization number from Medicaid, DHW, RMS, ACCESS, RMHA, EDS, Quality Improvement Organization (QIO), or MTU. Only one allowed on paper claims.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). **Example:** November 24, 2004 becomes 11242004 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24D 1	Procedure Code Number	Required	Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as three. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field 21.
24F	Charges	Required	Enter your usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H1	EPSDT Family Plan	Required if applicable	If the services performed are related to an EPSDT screen or Family Planning Visit, mark this field with an **X**.
24I	EMG	Desired	If the services performed are related to an emergency, mark this field with an **X**.
24K	Reserved for Local Use	Required if applicable	When a group, agency, or clinic is the billing agency, enter the Idaho Medicaid provider number of the provider rendering the service in Field 24K and the group provider number in field 33.
28	Total Charge	Required	Add the charges for each line then enter the total amount.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim. Do not enter contractual adjustments.
30	Balance Due	Required	Enter the total charges, less amount entered in amount paid field.

Field	Field Name	Use	Directions
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See Section 1.1.4 for more information.
33	Provider Name and Address	Required	Enter your name and address exactly as it appears on your provider enrollment acceptance letter or RA. If you have had a change of address or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33	GRP — Provider Number	Required	Enter your nine-digit Medicaid provider number.

3.4.3.4 Sample Paper Claim Form

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500